Lakeview Health Center/School Wellness Consent for Services

Student Name____**Birthdate**______/______/______

Please read the following statements and be sure that you understand each statement.

I give consent for my child to receive services as indicated in this document. By signing this consent, I certify that I am the legal guardian and legal custodian of the listed student. This consent begins on the date signed and will remain effective for the duration of enrollment in the Lakeview School District. I understand that I may withdraw my consent at any time with written notice to the Health Center or School Wellness Program (SWP).

The following services are available with consent:	
➢ Physical exams/school, sports, camps, and well child ➢ Treatment for acute illness and injuries ➢ Monitoring of chronic illnesses ➢ Health Education ➢ Immunizations	➢ Basic laboratory services and tests ➢ Administration of medication ➢ Screenings including data collection ➢ Behavioral Health services (individual, group, or family) ➢ Referrals for specialty services

Parental consent is not required for crisis intervention and emergency care.

I understand that minors may, without parental consent, receive advice, testing and/or treatment for drug abuse, substance abuse, sexually transmitted diseases, pregnancy testing, and referral for birth control services. There is no specific age set forth in the law. This applies to any minors who understand the nature and consequences of their actions. I further understand that a minor 14 years of age or older can, without parental consent, obtain limited outpatient mental health services not to exceed 12 visits over four months and not to include any medications.

No birth control pills or devices are dispensed or prescribed at the Health Center. The student will be given a referral list of community agencies that provide these services. No abortion counseling, referrals, or services are provided.

I authorize the Health Center to exchange health care information regarding treatment to other medical or mental health providers for the purpose of continuity and coordination of care, or to third party payers or others for the purposes of receiving payment for services. I agree to allow conversation with school staff when academic success is related to a health issue.

I understand that as an entity of the Calhoun County Public Health Department (CCPHD), the LHC/SWP participates in and recognizes the rules of the Health Information Portability and Accountability Act (HIPAA). In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information/records. Access to these records is not permitted without the consent of the student. In a medically-appropriate situation, pertinent information will be given to the parent/guardian and/or others as permitted or required by the law. The individual is also provided the right to request confidential communications or communications by alternative means such as to a cell phone instead of the home phone.

I have received a copy of the CCPHD Privacy Notice and Client Rights and Responsibilities (attached or available upon request).

I understand that testing for bloodborne diseases, including HIV/AIDS, may be performed upon a student without a separate written consent in the event that a healthcare professional from the Center sustains exposure to blood or body fluids from the student's open wound, mucous membranes, or occupational hazard.

I authorize the Health Center to bill my insurance company and release related information necessary to complete the billing process for services provided.

Student Name (Print):	**Grade:**
Student Signature:	**Date:**
Parent/Guardian Name (Print):	
Parent/Guardian Signature:	**Date:**

In addition, I authorize photographs to be taken of me/my child. I further authorize the CCPHD to use such photographs for the purpose of illustrations or publications. **Parent/Guardian Signature:**____________________________**Date:**__________________

For your convenience you may also consent to administration of immunizations including annual seasonal influenza. Immunization status will be evaluated using the Michigan Care Improvement Registry recommended vaccine schedule.

Parent/Guardian Signature: ____ **Date:** ______________________

OVER

Lakeview Health Center/SWP Registration & Health History

Student Information					
Student Last Name			**First**		**Initial**
Birth Date	Age	Male ☐ Female ☐	Grade	School	

Race: ☐Caucasian ☐African American ☐Hispanic ☐Asian ☐American Indian or Alaskan ☐Multi/Mixed ☐Other ______________________________________

Ethnicity: ☐Non-Hispanic ☐Hispanic ☐Arabic ☐Other ______________________________________

Street Address		City/State	Zip Code
Parent/Guardian: Last Name	First Name	M.I.	Relationship to Student
Home Phone # Cell #	Work Phone #	Student Cell #	
Name of Emergency Contact	Relationship to Student	Telephone #	
Pharmacy Preference	Pharmacy Location	Telephone#	

Preferred Method of Contact:
☐Phone: ( ) Home ( ) Cell ☐Written Communication ☐Other: ____

INSURANCE INFORMATION: Please complete ALL relevant areas below.

Insurance ☐Yes ☐No Please contact me about MIChild/Healthy Kids health Insurance for my child ☐Yes ☐No

Medicaid (Check One) ☐Meridian ☐McLaren ☐UnitedHealthcare ☐Other: ___________________		Medicaid ID#	
Primary Insurance and Address	Subscriber Name Subscriber Birth Date	Subscriber/Policy Number	Group #
Secondary Insurance and Address	Subscriber Name Subscriber Birth Date	Subscriber/Policy Number	Group #
Name of Student's Primary Care Physician Date of Last Physical		Name of Student's Dentist Date of Last Dental Exam	

DAILY MEDICATIONS: Please list any medications the student takes regularly.

	Name of Medicine	*Dose (mg)*	*Frequency*		*Name of Medicine*	*Dose (mg)*	*Frequency*
1				*3*			
2				*4*			

Allergies to Medications:

STUDENT HEALTH HISTORY: Please X the YES column if any of these conditions apply to the student or mark here for ☐ NONE.

Condition	*YES*	*Condition*	*YES*	*Condition*	*YES*	Other Conditions:
Bee Sting Allergies		Diabetes		Bladder Problems		
Food Allergies		Skin Problems		Backaches		Surgeries:
Seasonal Allergies		Headaches/Migraines		ADD/ADHD		
Do you carry an Epi-Pen?		Seizure/Epilepsy		Anemia		Hospitalizations:
Asthma		Fainting		Sickle Cell Disease		
Shortness of Breath		Concussion		High Blood Pressure		Explain all yes answers:
Pneumonia		VP Shunt		Vision Problems		
Stomach Problems		Kidney Disease		Heart Problems		

Please mark any boxes that an immediate family member (parents/siblings) has a medical history of:

Heart Problems		Cardiac Death Before Age 50		High Blood Pressure		High Cholesterol	
Asthma/Emphysema		Allergies		Tuberculosis		Smoking	
Cancer		Diabetes		Obesity		Stroke	
Seizures		Depression/Mental Illness		Other:			